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Program Environments of Self-Help Agencies for Persons With Mental Disabilities

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Abstract

Leaders of self-help agencies (SHAs) aspire to develop program environments that are different from community mental health agencies (CMHAs). This article addresses two questions. Do consumers' perceptions of SHAs approximate the characteristics leaders think ought to typify such agencies? Do SHA and CMHA consumers differ in their program perceptions? Using the Community-Oriented Program Environment Scale, leader expectations of ideal SHA environments were obtained from a national survey of 189 consumer-run agency heads, perceptions of actual environments from interviews with 310 SHA consumers, and perceptions of CMHAs from questionnaire responses of 779 consumers in 54 programs. SHA reality conforms to ideology in offering opportunities for consumers to experience involvement, support, and autonomy in the receipt of needed service. While showing only modest differences from CMHAs on relationship and treatment characteristics, SHA consumers differ in their perceived control over program rules, a fact previously found significant in promoting positive outcomes.

Introduction

Consumer perceptions of program environments have important implications for mental health organizations. Such perceptions have been linked to outcomes in psychiatric inpatient units^{1,2} and drug rehabilitation programs,^{3,4} have guided programmatic changes in community-based mental health settings,^{5,6} and have enabled comparisons between different types of mental health interventions.^{4,7} This study considers the program environments of self-help agencies (SHAs) and attempts to answer two questions. First, do consumers' perceptions of SHAs approximate their leader's notion of the ideal agency? Second, do SHA and professionally run community mental health agency (CMHA) consumers differ in their program perceptions?

The National Association of State Mental Health Program Directors (NASMHPD) holds that client-operated self-help and mutual support services should be available in each locality as alternatives and adjuncts to existing mental health service delivery systems and that state support for such services should be provided.⁸ The Community Support Program, Center for Mental Health Services, has and continues to support consumer-run program development.⁹

SHAs are programs that are planned and operated by consumers of mental health services. In them, consumers control major organizational decisions by excluding professionals, by granting consumer control over professionals, or by having a consumer as an agency director. SHAs provide a gamut of services, including peer counseling, benefits and housing assistance, money management assistance, advocacy, and survival resources, as well as a drop-in component.^{10–13} Some target homeless persons with severe mental disabilities.^{10,14,15} Typically, SHAs have participatory structures that allow considerable membership involvement in agency decision making. Mutuality, voluntariness, egalitarianism, and nonmedical orientation are essential SHA characteristics.^{16–18} According to self-help leaders, these principles create qualitatively different program environments that consumers experience as more empowering than those they encounter in CMHAs run by professional providers.^{19–24}

Thus far, information on consumers' perceptions of SHAs has been reported in cross-sectional surveys of mental health clients¹¹ or in evaluative studies of drop-in centers and their participants.^{12,20,26} Few reports are available on whether the program environments of SHAs actually conform to the ideals of their leaders or on comparative perceptions of program environments by consumers in SHAs and CMHAs.

Methodology

Samples

Three comparison samples were used: a national survey of SHA leaders and two California surveys of SHA and CMHA participants.

The leader survey was conducted by the Center for Self-Help Research (CSHR). SHAs usually have funding and are likely to be involved in advocacy with their mental health systems. CSHR, therefore, began with a nationwide list compiled by state Community Support Program directors for the Community Support Program of the Center for Mental Health Services. The list was augmented by a similar list compiled by NASMHPD and lists provided by the National Empowerment Center in Boston, the Self-Help Clearinghouse in Philadelphia, and the National Depressive and Manic-Depressive Association. In all, surveys were sent to 430 organizations; 189 (44%) returned them. Of these, 179 identified themselves as SHAs.

Based on consumer writings, we defined an SHA by its conformity to at least one of three criteria: it had no professional members; if professionals were involved, consumers had the power to dismiss them; and the organization was consumer directed. For the 179 responding organizations, initial screening questions revealed that 68 (38%) had no professional participants, 91 (51%) had professional participants who could be dismissed by consumers,

and 14 (8%), though failing to satisfy the latter two conditions, had a consumer director. Four (2%) did not respond to the screening questions, and 2 (1%) failed to meet any of the screening criteria. No statistical differences were observed between SHAs with and without professionals on leader evaluations of 45 definitions of empowerment and on more than 100 organizational characteristics. Chi-square analyses yielded no differences in response rate by geographical location.

The SHA consumer sample included 310 respondents from four California organizations. Three targeted their services to homeless persons with mental disabilities, the fourth to all persons with mental disabilities. Consumers at all agencies are very poor and often suffer from drug and alcohol problems. To minimize selection bias, people were impaneled at different times of the day. Ninety-six percent of those offered an interview accepted. Data on the organization and their membership are reported elsewhere.²⁷ While there are no good data on the comparability of consumers using these SHAs with those in other areas, their demographics were similar to those of mentally disabled homeless people in the San Francisco Bay area and in other urban areas.^{28,29}

The CMHA consumer sample included 779 respondents drawn from a broad range of community programs. These data were gathered and analyzed by Moos and colleagues for the purposes of norming the Community-Oriented Program Environment Scale (COPES).³⁰ The sample included 54 programs primarily located in California (87%). Programs studied included day care centers, rehabilitation workshops, partial hospitalization programs, halfway houses, one out-patient support group, and one patient-run self-help unit. Programs were administered by state, county, psychiatric, and general hospitals; the Veterans Administration; and private organizations.

Measurement

The COPES is one of the few instruments believed to measure the character of social interactions in service settings.³¹ It is a 100-item true-false instrument. Each item is a statement about the structural, process, or interpersonal relationships within the service program. Moos's COPES³¹ consists of 10 subscales of 10 items, each covering three content areas. A summary of the content of each of the 10 COPES subscales is provided in Table 1. Average internal consistency for the subscales is reported at .66, average test-retest reliability at .75, and average item-to-subscale correlation at .48.³⁰ While COPES subscales are convenient for the comparison of SHAs and CMHAs, they may not fully represent the dimensional structure of the former as perceived by consumers.

Analyses

Content validity.—Three procedures were used to test whether the 10 COPES subscales had the same meaning for the SHA as for the CMHA. Prior to gathering the study data, all COPES items were reviewed first by researchers and consumers. Items not relevant to the operation of the SHA were eliminated. Remaining items in each of the 10 subscales were weighted to add to a total score of 10. Second, in a separate cluster analysis of each subscale, we tested its unidimensionality in the SHA consumer and leader samples. Observed subclusters of items within a given subscale were tested to determine whether, on

average, their relation to each other was nonsignificant (i.e., had a nonsignificant average zero-order intersubcluster correlation coefficient). A *t*-test evaluated the significance of the average intersubcluster *r*. Any deviation from unidimensionality and items not related to other subscale items were recorded. We used this to determine whether the observed lack of relationship of these items appeared to alter the attributed meaning of the subscale.

Conformity of perceived reality with ideals.—To answer the first study question (i.e., the conformity of SHA program environments with self-help ideals), comparisons were made between the leaders' descriptions of the "successful SHA" using the COPES and consumers' actual perceptions of the four SHAs on the same items. Difference of means tests (*t*) contrasting the subscale means of the two sets of respondents—179 (leaders) and 316 (consumers)—were carried out with 463 degrees of freedom and separate variance estimates.

Differences between self-help and mental health programs.—In addressing the second study question, the difference between SHAs and CMHAs, the means of SHA consumers and SHA leaders were converted to standard *T*-scores. SHA standard score equivalents in both self-help samples were calculated on the basis of consumer norms for outpatient CMHA settings in the Moos²⁹ sample. Given these conversions, it is possible to compare the process environment of SHAs against the standard of the 54 CMHA programs surveyed by Moos.

Results

Differences in COPES Subscale Meaning

It was discovered that all subscales were unidimensional in the SHA and leader samples, save for staff control. Here, unique item content altered the subscale's substantive meaning. A cluster analysis indicated three separate dimensions, one common dimension, and two unique items. The average internal correlation for the one common cluster—that is, the cluster offering meaning to the subscale in the SHA consumer sample—was $r = .30$; the average external correlation to the other unique items in the staff control scale was $.04$. In the leader sample, the similar correlations were $r = .20$ versus $.08$. The two nonsignificant items in the subscale are important because they alter the meaning of the staff control subscale in the SHA context. The unique items are (1) "staff don't order consumers around" and (2) "consumers can call staff by their first names." The remaining items are best described by the item: "it is important to carefully follow the rules here," No mention of staff is made in any of the other items remaining in the common cluster. Since consumers make the rules in the SHA and vote on their enforcement, the scale—called "Staff Control" by Moos—in the self-help agency is best interpreted as the "importance of conformity with consumer initiated rules." This changes the scale meaning by shifting the focus of the common response variance from a staff-control to a consumer-control subscale. Unique items are retained in the scale since they are unrelated to the common variance and make comparisons below possible. For convenience, reference is made to this subscale as "control."

Contrasting SHA Ideals and SHA Reality

To address the relationship between self-help ideals and consumer perceptions, Figure 1 includes the mean scores on each of the 10 COPEs subscales for SHA consumers and leaders. Leaders used COPEs to describe “the successful self-help agency.” Consumers described their actual SHA. All between-sample scale means, with the exception of those describing order and organization, were significantly different ($p < .000$; see Figure 1). The greatest differences occurred in the relationship variables (involvement, support, and spontaneity), over 2½ points on average. Spontaneity showed the greatest divergence between ideals and reality. Even though the greatest differences between leaders and consumers were in the relationship scales, consumer scores on these scales tended to be higher on average than on the program or administrative scales. The surprise was the high scores in the area of administrative concerns—order and organization, program clarity, and control. Consumers reported control scores significantly higher than leaders. There were no significant differences in order and organization, but leaders showed significantly higher scores in program clarity.

The subscale scores were also rank ordered. For both consumers and leaders, the top five scores included involvement, support, autonomy, and program clarity. However, SHA leaders include spontaneity in their top five (ranked fourth), while consumers view control as the top-ranked component among their top five. While involvement, support, and autonomy rank 1, 2, and 3 among the leaders, they rank 2, 3, and 5 among the consumers.

Comparing SHA Ideals and Experience With CMHA Environments

In Figure 2, the raw scores of leaders and SHA consumers have been normed against Moos’s CMHA samples. COPEs scale means of the self-help samples are presented as standard *T*-scores, with a mean of 50 and standard deviation of 10. The emboldened line with a score of 50 in Figure 2 marks the average CMHA score on each COPEs scale. Since normalized *T*-scores were used, it is possible to assess the proportion of organizations at or below the level reported by SHA leaders and consumers on each of the scales. The observed leader mean on involvement is almost two standard deviations above that of the average CMHA, indicating that self-help leaders have high expectations for their organizations. They seek involvement scores 47.6% greater than the average CMHA actually delivers. Similarly, they seek support scores that are 46.1% higher, spontaneity scores that are 44.5% higher, and autonomy scores that are 45.1% higher. In considering other scales, the expectations are a little lower but still ambitious in that they wish practical orientation scores to be 33.1% higher, personal problem scores to be 41.5% higher, anger and aggression scores to be 34.6% higher, program clarity scores to be 32.9% higher, and control scores to be 41.6% higher. SHA leaders further do not value the same level of order and organization observed in CMHAs. Successful SHAs should have order and organization scores 20.1% lower than those observed in the average CMHA.

Consumers describe a more modest SHA. The four agencies that were studied had an involvement score mean 26% above the average CMHA. They were 8.7% above on support, 14.4% above on spontaneity, 16.3% above on autonomy, 18.7% above on personal problems, 24.2% above on anger and aggression, 8.7% above on program clarity, and 47% above on

control. On practical orientation, SHAs scored lower than the CMHA by 9.9%, as they did in the area of order and organization by 27.3%. Perhaps the most significant finding is the relative emphasis by both SHA leaders and consumers on rule conformity.

Discussion

Self-help leader aspirations for program environments were first compared with consumer perceptions. Though significantly different, both strongly emphasize involvement, support, and autonomy, demonstrating the consistency of the self-help ideology with practice.

The change in meaning of the COPEs staff control subscale to a consumer control subscale is key to assessing the unique program environments of SHAs. These agencies attempt to promote participatory structures and processes that enable consumers, who typically have had little decision-making power within other institutions and agencies, to define formal rules within the SHAs. They may thus be achieving this goal.

Results indicate that consumers see less spontaneity in their program environments than the leaders' ideal. The spontaneity scale includes free discussion of feelings and nonregulated activities. Given the kinds of behavioral problems created by substance abuse, spontaneity may be less desired by consumers dealing with the everyday reality of the organization. They may well welcome some regulation of speech and actions.

The difference in the experience of program environments between consumers at SHAs and those at CMHAs was also addressed. The absence of significant differences in the relationship variables (involvement, support, and spontaneity) between SHAs and the CMHAs in the normed comparisons does not support assertions that SHAs are experienced as more supportive and accepting places than professional mental health services. But, seen from another perspective, SHAs are found to perform at least as well as professionally provided services in relationship and program areas. Such findings suggest that SHAs are not marginally functioning programs but can provide positive program environments similar to those of their professional counterparts, although the service "packages" they provide and their participatory structures distinguish them from CMHA programs.

Finally of note is the agreement between SHA leaders and consumers on a lack of emphasis on order and organization (i.e., activity planning and neatness) and the trend indicated in the data showing that SHAs tend to be perceived as below the average CMHA on this aspect of their program environment. Unfortunately, such program characteristics, while held in less import in SHA ideology, may contribute to reinforcing mental health professional stereotypes of consumers as incompetent^{32,33} to run orderly and organized programs.

Several limitations to this study derive primarily from unknowns associated with sample membership. Observed differences between SHA ideology and reality may only generalize to differences between the four California SHAs, which have a predominantly homeless and marginally housed membership and the national leader sample. But the focus on shared control in both the SHA leader and member samples leads us to conclude that the national sample does not misrepresent the reality of the field, albeit a reality tested only in four California settings. Differences in the timing of the SHA and CMHA studies might also

account for differences observed in the CMHA and SHA membership samples. Yet, the responses observed are more notable for their similarities than for their differences.

Implications for Mental Health Policy and Administration

Differences in consumer and leader perspectives are indicative of directions for program improvement and cautions for organizations that wish to support SHA development. Organizations that support the development of SHAs should be clear that the mechanisms of consumer control and community development are built into the structure of the organizations they support. Only in this way can we be assured that the observed gaps between self-help ideology and reality in the area of relationship are minimized.

Leaders in SHAs should focus on understanding the mechanisms to bring more spontaneity/trust into their settings in situations complicated by substance abuse issues that often require vigilance and structure. Most important, leaders and funders of SHAs need to recognize the importance of member control in the views of agency participants. The increased sense of personal efficacy deriving from perceived control of the helping process has been associated with positive individual outcomes.³⁴ While it is easier to rely on a staff control model, observations of more successful settings have indicated that the apparent internalization of the “control” agenda by members leads to more productive, if not necessarily more controlled, organizations. Further, the data seem to indicate that, like reputable CMHAs, the SHA has significant organizational control of its service activities.

Funding agencies, professionals, and evaluators must avoid an overemphasis on order and organization in their judgments of SHA performance. They need to emphasize evaluative criteria more consistent with SHA ideology. Primarily, their focus should be on the implementation of control, involvement, support, and autonomy issues. Failing this tack, they are likely to misjudge the competencies of the SHA on what may be superficial and stereotyped criteria.

The successful growth of SHAs seems to offer a new and complementary service option. It offers the opportunity for consumers to experience involvement support and autonomy in the receipt of needed service. Promoting such involvements in the CMHA may be a viable strategy for meeting service needs that are unfulfilled in the face of service cuts.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1. COPES Subscale Scores: SHA Consumers and Leaders

* *t*-test with *ns* = 179 (leaders) and 310 (consumers), *df* = 463.36 and separate variance estimates.

Figure 2. Mean COPES Subscale Scores: SHA Consumers and Leaders Versus CMHA Consumers

Note: *T*-score subscale means are converted per CMHA program norms provided by Moos.

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Table 1**Conceptualization of COPES Dimensions**

I. Relationship
1. Involvement: How active consumers are in the day-to-day functioning of their program.
2. Support: The extent to which consumers are encouraged and supported by staff and consumers.
3. Spontaneity: The extent to which the program encourages consumers to act openly and express feelings openly.
II. Program descriptors
4. Autonomy: How self-sufficient and independent consumers are encouraged to be in making their own decisions.
5. Practical orientation: The extent to which the consumers' environment orients them toward preparation for release from program. This implicitly combines two concepts: preparation for program release and orientation toward intermediate- and long-term goal attainment (e.g., getting skills, finding jobs, etc.), regardless of the level of ongoing involvement with the agency.
6. Personal problems: The extent to which consumers are encouraged to be concerned with their personal problems and feelings and to seek to understand them.
7. Anger and aggression: The extent to which a consumer is allowed and encouraged to argue with consumers and staff, to become openly angry, and to display other aggressive behavior.
III. Administrative structure
8. Order and organization: How important activity planning and neatness are in the program.
9. Program clarity: The clarity of goal expectations and rules.
10. Control: The degree to which rules are understood, enforced, and followed.